



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE SUMMIT SURGERY CENTER
3801 WEST 15TH STREET
PLANO TX 75075

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-4100-01

MFDR Date Received

JULY 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The cpt 26765 was denied as a duplicate. This code is on this claim 1 time."

Amount in Dispute: \$7616.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Provider is not entitled to additional reimbursement for two reasons. First, the Provider was not entitled to separate reimbursement for both units of CPT code 64702, despite the use of the -59 modifier...Second, the total reimbursement already issued to the Provider exceeds the additional amount requested, based on the inclusion of reimbursement for both CPT code 64702-59 and CPT code 26765. As documented above, the Provider was reimbursed \$853.73 for CPT code 64702. The Provider requests an additional \$1,182.21 for CPT code 26765. This would produce total reimbursement for these codes of \$2,035.94. As the Carrier has already reimbursed \$2,357.34 erroneously under CPT code 64702, this exceeds the additional reimbursement the Provider is seeking in the Table of Disputed Services."

Response Submitted by: Travelers, 1501 S. Mopac Expwy, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2010	ASC Service for code 26765-SG-F6	\$7616.00	\$1178.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.260 , effective May 2, 2006, sets out the procedures for requesting refunds of payments.
3. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 22, 2011

- 18-Duplicate claim/service. The listed service/procedure cannot be billed in multiple increments on the same day or exceed the maximum number of services for this claim.

Explanation of benefits dated June 22, 2011

- 18-Duplicate claim/service. Duplicate charges.
- 18-Duplicate claim/service. These services have already been considered for reimbursement.

Explanation of benefits dated July 5, 2011

- 18-Duplicate claim/service. The listed service/procedure cannot be billed in multiple increments on the same day or exceed the maximum number of services for this claim.
- W1-Workers Compensation state fee schedule adjustment. This bill has been processed correctly per the state fee schedule.

Issues

1. Is code 26765-SG-F6 a duplicate of another claim/service rendered on the disputed date of service?
2. Is the respondent's position summary filed in accordance with 28 Texas Administrative Code § 133.307(d)(2)(B)?
3. Is the requestor entitled to reimbursement for code 26765-SG-F6?

Findings

1. The respondent denied reimbursement for code code 26765-SG-F6 based upon reason codes "18-Duplicate claim/service. The listed service/procedure cannot be billed in multiple increments on the same day or exceed the maximum number of services for this claim".

A review of the submitted medical bill does not support that code 26765-SG-F6 was a duplicate of any other service billed on this date; therefore, the denial reason code "18" is not supported.

2. The respondent states in the position summary that "...the Provider is not entitled to additional reimbursement for two reasons. First, the Provider was not entitled to separate reimbursement for both units of CPT code 64702, despite the use of the -59 modifier...Second, the total reimbursement already issued to the Provider exceeds the additional amount requested, based on the inclusion of reimbursement for both CPT code 64702-59 and CPT code 26765. As documented above, the Provider was reimbursed \$853.73 for CPT code 64702. The Provider requests an additional \$1,182.21 for CPT code 26765. This would produce total reimbursement for these codes of \$2,035.94. As the Carrier has already reimbursed \$2,357.34 erroneously under CPT code 64702, this exceeds the additional reimbursement the Provider is seeking in the Table of Disputed Services."

28 Texas Administrative Code § 133.260(a) states "An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided."

The requestor did not submit documentation to support that a refund for overpayment was requested for CPT code 64702 prior to the date the request for MDR was filed; therefore, this is a new issue. In addition, CPT code 64702 is not listed on the Table of Disputed Services only 26765.

28 Texas Administrative Code § 133.307(d)(2)(B) states in part "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

A review of the submitted Table of Disputed Services does not include CPT code 64702, only 26765. Therefore, the issue regarding overpayment for code 64702 is not part of this dispute and will not be considered further.

3. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM

AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

CPT code 26765 is defined as "Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each".

Per Rule 134.402(f)(1)(A) reimbursement for non-device intensive procedure for CPT code 26765 in Plano, TX is:

The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2010 for code 26765 = 24.1337.

This number multiplied by Medicare ASC Conversion Factor of $\$41.873 \times 24.1337 = \1010.55 .

The national reimbursement is divided by 2 = $\$1010.55/2 = \505.27 .

This number X City Conversion Factor/CMS Wage Index for Plano, TX is $\$505.27 \times 0.9853 = \497.84 .

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $\$505.27 + \$497.84 = \$1003.11$.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $\$1003.00 \times 235\% = \2357.30 .

CPT code 26765 is subject to multiple procedure rule discounting; therefore, $\$2357.30 \times 50\% = \1178.65 .

The MAR for CPT code 26765-SG-F6 is \$1,178.65. The respondent paid \$0.00. The difference between the MAR and amount paid is \$1178.65.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$1178.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1178.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

6/18/2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.